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Improving Primary Care Access for the Housing Insecure in Washington County

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Kristina Valentine,MS3

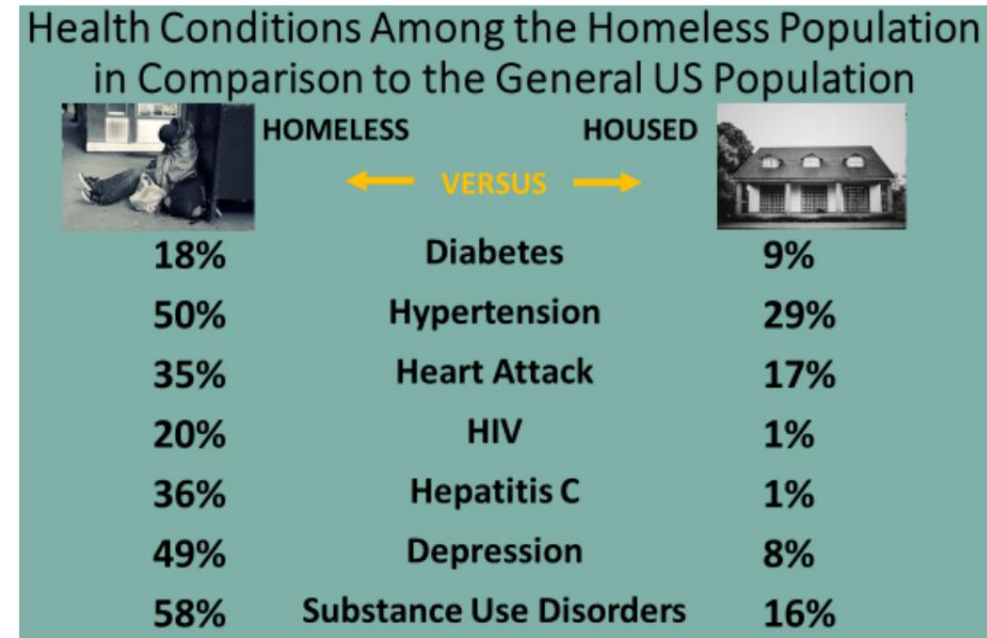
LIC 2020-2021

Mentor: Dr. Jeremiah
Eckhaus

Improving Primary Care Access for the Housing Insecure in Washington County

Problem Identification: “Poor health is both a cause and a result of homelessness¹”

- Common barriers in obtaining care²
 - Insurance issues
 - Competing priorities (agency time)
 - Mistrust of healthcare/experiences of discrimination
 - Transportation (especially rural)
- At higher risk for severe COVID-19 infection due to close living quarters and comorbidities²
- Primary care offers an opportunity to build trust and helps prevent illness and death³, but housing insecure have worse access⁴
 - more likely to not have routine check-ups and lack access to usual sources of care⁴



Source: Health Center Patient Survey (HCPS) 2009

Public health cost/cost considerations in USA, VT, and Washington county

- National data: In rural areas, one half of ED visit costs were for patients from the lowest income communities.³
- Vermont data: 77% of housing insecure households had at least one family member with at least one episode of care in the emergency, inpatient, or observation category in 6 months. Cost to Medicaid: \$383,705
 - This rate ultimately decreased to 68% 18 months after the state introduced a rapid-rehousing intervention. Cost to Medicaid: \$187,144.⁵
- Washington County/CVMC
 - 6% of high ED utilizers are housing unstable
 - 1.8% of homeless population are high ED utilizers vs .02% general population
 - =housing insecure 10x more likely to be a high ED utilizer

Interviews with community members

“Identifying the healthcare needs of people experiencing homelessness and barriers to accessing appropriate and timely care has historically been underemphasized in our work in Washington County as a system of care.” -Will Eberle, Field Director, Washington and Lamoille Co, VT Agency of Human Services

“The homeless struggle with just getting their daily needs met and a lot of them don't think about their health and we need to help people think and start to engage with getting a medical home.” –Barbara Jenne, Housing Manager, Good Samaritan Haven

“Poor or no access to medical care is a major contributing factor to homelessness. It exacerbates other factors such as poverty, unemployment and lack of affordable housing. COVID magnified this risk but it has always been the case for those experiencing the trauma of homelessness.” –Rick DeAngelis, Executive Director, Good Samaritan Haven

An opportunity in the time of COVID- 19

In response to the COVID 19 Pandemic, the State of VT provided housing vouchers and community organizations rallied to provide services for people experiencing homelessness and made housing available in local hotels.

Simultaneously, primary care practices across the State implemented telemedicine to prevent the spread of disease.

This combination of factors created a unique opportunity for a project.

Intervention and methodology

Global Aim:

- Connect people experiencing homelessness to PCPs

Specific Aims:

- Understand barriers to primary care for housing insecure in Washington Co.
- Identify how many individuals are already connected to care
- Facilitate connection to a PCP if not connected

Methodology:

- Quality Improvement Study
- Regularly visit 2 local hotels that are currently housing the housing insecure in Washington Co.
- Administer survey to residents about current connection to healthcare and barriers to care
- Work with local primary care offices to facilitate connection to services
- Monitor number of appointments made, attended, and missed

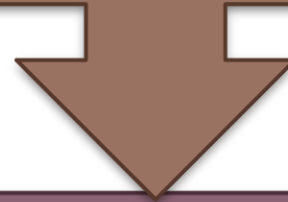
1. Do you have a doctor you see regularly? If not, where do you go when you are sick? Example: ED, Express Care, Urgent Care, Other
2. If no to number 1, what has stopped you from seeing a doctor? Examples: transportation, past experience was poor, no phone, no health insurance, other
3. Do you have a dentist? If not, where do you go when you need dental care?
4. Do you have a smart phone/tablet to use when you need to see your doctor? Yes/No
5. What else would help you to see a primary care doctor or dentist?
6. Do you have health insurance?
7. Are you currently working with any community agencies? Example: WCMC, FCWC, CIS, CVHHH, SASH, other
8. Have you ever participated in a telemedicine visit?
9. What type of device (laptop, phone) do you usually use to access the internet?

The Survey



Results

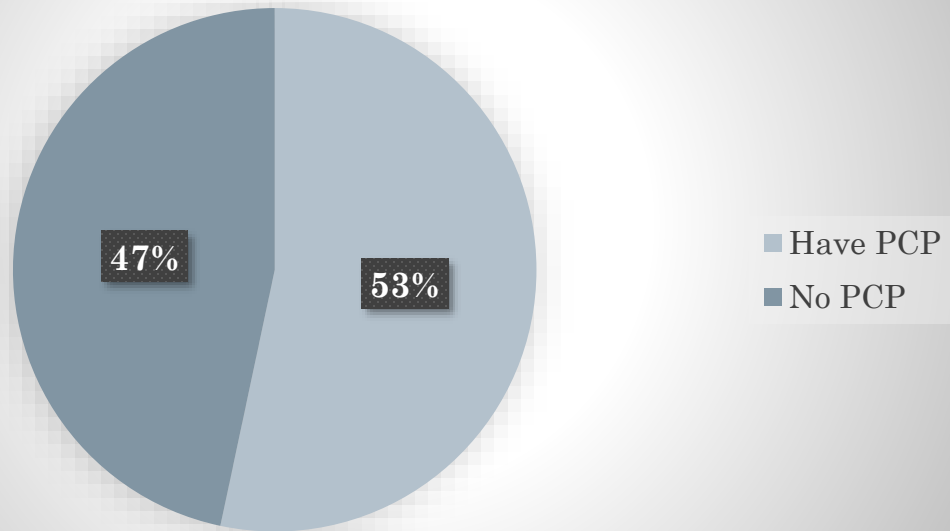
Went to hotels 6 times
from Dec-March



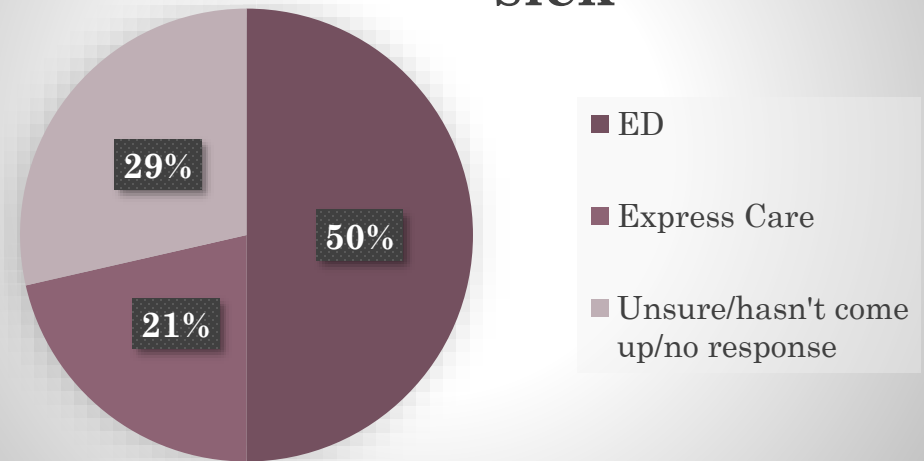
Surveyed 60 residents

Results

Self-reported PCP

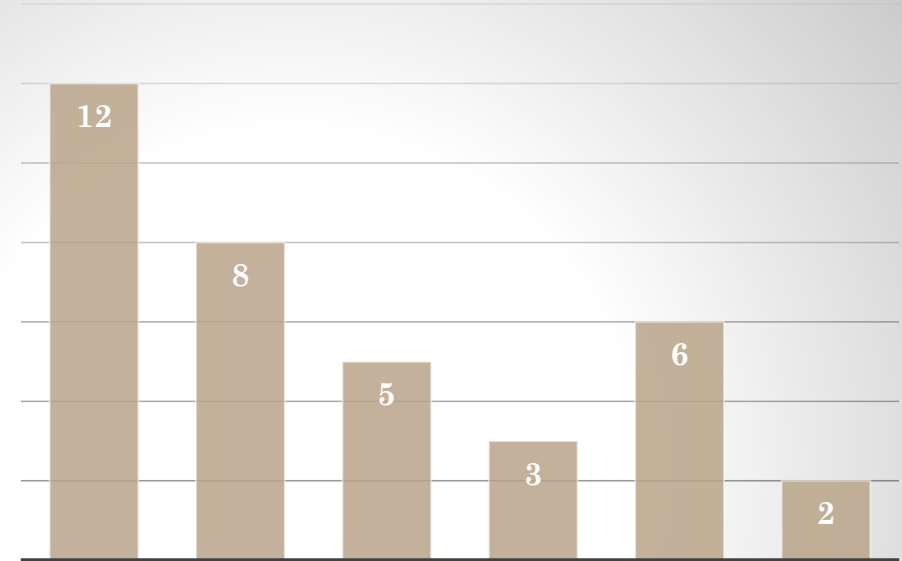
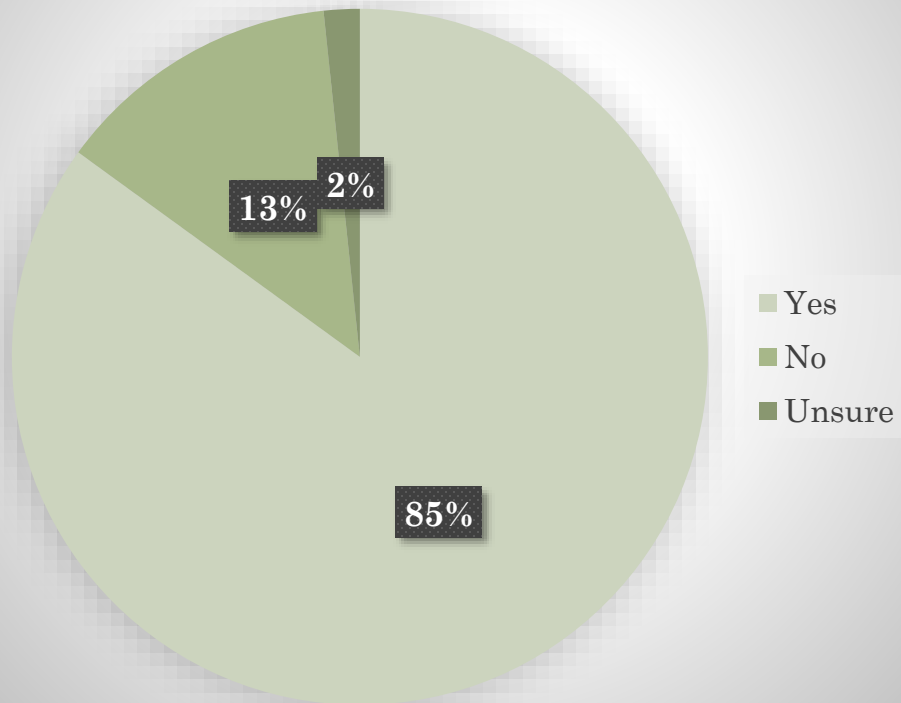


No PCP, where go when sick



Results

Self-Reported Health Insurance



Most common barriers

- 16 individuals interested in connection w/ PCP (57% of eligible)
- 8 individuals referred to PCP (50%)
- 3 with an appointment scheduled by 3/8
 - Plus one contacted for appt and deferred
- 2 individuals completed at least one appointment by 3/8
 - 1 telemedicine visit with in-person assistance of medical student
 - 1 in-person visit
- 1 no-show by 3/8

Evaluation of
Effectiveness:
Number of
housing insecure
individuals
connected to
primary care

Limitations

- Housing in hotels ending July 1, difficult for future follow-up
- Continue connection with Good Samaritan

Limitations

- Barriers I faced connecting individuals to primary care
 - Intake process still mainly via phone/mailed paperwork
 - Lack of knowledge/resources at provider offices to give housing insecure individuals the extra support they need to make and keep appointments
 - Very little connection to dentistry practices

Limitations

- Concern: that barriers will limit ability for patients to make PCP appointments once connected, increasing time waste for providers
 - Already have had one no-show

Recommendations for future interventions/projects



Have local physicians be a presence at hotels/shelters and/or do home visits



Make requests for care/intake paperwork electronic



Education efforts on the importance of preventative medicine



More collaboration with dentistry



Cultural competency training at PCP offices on the special and unique needs of the housing insecure

Recommendations ctnd



Streamlining and normalizing the use of telemed in this population



Consider a health navigator for the housing insecure at PCP offices or through organization like Good Sam



Assess ED utilization rates in this population after interventions

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